Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
5445 LA SIERRA DRIVE 204
DALLAS TX 75231

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-3157-01

MFDR Date Received
MARCH 8, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Separate procedure and is not global with any other code."

Amount in Dispute: $2,414.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed amount on the DWC-60 is $2,414.88. Biofeedback was preauthorized and some reimbursement was made under other CPT codes for these dates of service. CPT code 90901 was not reimbursed per the EOB because 'Payment adjusted due to a submission/billing error. Additional information is supplied using the remittance advice remarks code whenever appropriate."

Response Submitted by: CHARTIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2009 November 13, 2009 December 21, 2009 December 28, 2009	CPT Code 90901 (12)	$603.72 X 4 = $2,414.88	$804.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out reimbursement guideline for medical professional services.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 125-Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.

Issues

1. Does the documentation support billed service?
2. Is the requestor entitled to reimbursement?

Findings

1. CPT code 90901 is defined as "Biofeedback training by any modality."

   According to the explanation of benefits, the respondent denied reimbursement based upon reason code 150."

   A review of the submitted medical bill finds that the requestor billed for twelve units of CPT code 90901.

   A review of the submitted report states the following: "DESCRIPTION OF TREATMENT PROVIDED: Baseline data was obtained. Biofeedback training included: pain control techniques, instruction in abdominal breathing, and guided imagery. Types of feedback: visual and audio."

   The Division finds the baseline data was obtained for the following: EMG, SC/GSR, TEMP and PNG; therefore, the documentation supports four modalities not twelve. Therefore, reimbursement is recommended for four modalities.

2. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2009 DWC conversion factor for this service is 53.68.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75231, which is located in Dallas County. The Medicare conversion factor for Dallas County is 36.0666.

   The Medicare participating amount for code 90901 in Dallas County is $33.77.

   Using the above formula, the MAR is $50.26. $50.26 multiplied by 4 modalities = $201.04. $201.04 multiplied by four dates of service = $804.16. The respondent paid $0.00. The requestor is due $804.16.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 804.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $804.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/14/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.